

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0031906</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Genesis House</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>6/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>350 Sycamore Road</u> <u>Genoa</u> <u>60135</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>DeKalb</u>		(Signed) _____ (Date) _____																									
Telephone Number: <u>(815) 784-5146</u> Fax # <u>(815) 785-2594</u>		(Type or Print Name) _____																									
IDPA ID Number: <u>363480754002</u>		(Title) _____																									
Date of Initial License for Current Owners: <u>12/8/1986</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																									
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		Paid Preparer (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # (312) 634-5518	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Genesis House# 0031906 Report Period Beginning: 07/01/02 Ending: 6/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>60</u>	Intermediate/DD	<u>60</u>	<u>21,900</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,900</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>21,488</u>			<u>21,488</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,488</u>			<u>21,488</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.12%

D. How many bed-hold days during this year were paid by Public Aid?

366 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/07/1986

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 12/07/1986NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐ NO ☒Tax Year: 12/31/03 Fiscal Year: 6/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Genesis House

0031906

Report Period Beginning:

07/01/02

Ending:

6/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	100,348	3,519	7,230	111,097		111,097		111,097			1
2	Food Purchase		101,135		101,135		101,135	(11,742)	89,393			2
3	Housekeeping	78,301	19,864		98,165		98,165		98,165			3
4	Laundry	12,113	10,164	390	22,667		22,667		22,667			4
5	Heat and Other Utilities			49,774	49,774		49,774		49,774			5
6	Maintenance	38,742	14,217	41,063	94,022		94,022	(12,956)	81,066			6
7	Other (specify):*											7
8	TOTAL General Services	229,504	148,899	98,457	476,860		476,860	(24,698)	452,162			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	705,089	19,394	129,887	854,370		854,370		854,370			10
10a	Therapy			8,638	8,638		8,638		8,638			10a
11	Activities	45,648	2,794	2,726	51,168		51,168		51,168			11
12	Social Services	6,014		1,036	7,050		7,050		7,050			12
13	Nurse Aide Training	30,412	347		30,759		30,759		30,759			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	787,163	22,535	166,287	975,985		975,985		975,985			16
	C. General Administration											
17	Administrative	268,810			268,810		268,810		268,810			17
18	Directors Fees											18
19	Professional Services			91,660	91,660		91,660	11,585	103,245			19
20	Dues, Fees, Subscriptions & Promotions			5,529	5,529		5,529	1,582	7,111			20
21	Clerical & General Office Expenses	84,733	6,498	20,224	111,455		111,455	(1,470)	109,985			21
22	Employee Benefits & Payroll Taxes			155,067	155,067		155,067	11,742	166,809			22
23	Inservice Training & Education			1,766	1,766		1,766		1,766			23
24	Travel and Seminar			4,585	4,585		4,585		4,585			24
25	Other Admin. Staff Transportation			12,817	12,817		12,817		12,817			25
26	Insurance-Prop.Liab.Malpractice			42,529	42,529		42,529	260	42,789			26
27	Other (specify):*											27
28	TOTAL General Administration	353,543	6,498	334,177	694,218		694,218	23,699	717,917			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,370,210	177,932	598,921	2,147,063		2,147,063	(999)	2,146,064			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,524	36,524		36,524	15,307	51,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,313	51,313		51,313	6,119	57,432			32
33	Real Estate Taxes							19,710	19,710			33
34	Rent-Facility & Grounds			211,710	211,710		211,710	(211,710)				34
35	Rent-Equipment & Vehicles			45,136	45,136		45,136		45,136			35
36	Other (specify):*											36
37	TOTAL Ownership			344,683	344,683		344,683	(170,574)	174,109			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			3,200	3,200		3,200		3,200			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,520	192,520		192,520		192,520			42
43	Other (specify):* Nonallowable Costs			871,701	871,701		871,701	(871,701)				43
44	TOTAL Special Cost Centers			1,067,421	1,067,421		1,067,421	(871,701)	195,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,370,210	177,932	2,011,025	3,559,167		3,559,167	(1,043,274)	2,515,893			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	2,707	30		9
10 Interest and Other Investment Income	(23,553)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(624)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(150)	20		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(594)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	(4,000)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Sch 5A	(857,519)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (883,733)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	(159,541)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (159,541)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,043,274)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Genesis House

ID# 0031906

Report Period Beginning: 07/01/02

Ending: 6/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

Genesis House
Provider # 0031906
6/30/2003

Schedule 5A

Schedule VI. Part A - Adjustment Detail, Line 29

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Day Training	(863,873)	43
Vending Machines	(2,610)	43
Deferred Maintenance	988	6
Miscellaneous Income	7,976	n/a
Total	<u><u>(857,519)</u></u>	

See Accountants' Compilation Report

Summary A

6/30/03

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[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Genesis House# 0031906

Report Period Beginning:

07/01/02

Ending:

6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,707	12,600	0	0	0	0	0	0	0	0	0	15,307	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,553)	29,672	0	0	0	0	0	0	0	0	0	6,119	32
33	Real Estate Taxes	0	19,710	0	0	0	0	0	0	0	0	0	19,710	33
34	Rent-Facility & Grounds	0	(211,710)	0	0	0	0	0	0	0	0	0	(211,710)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,846)	(149,728)	0	0	0	0	0	0	0	0	0	(170,574)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,218)	0	0	0	0	0	0	0	0	0	0	(5,218)	43
44	TOTAL Special Cost Centers	(5,218)	0	0	0	0	0	0	0	0	0	0	(5,218)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(26,214)	(151,565)	0	0	0	0	0	0	0	0	0	(177,779)	45

Facility Name & ID Number Genesis House# 0031906

Report Period Beginning:

07/01/02

Ending:

6/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Catherine Bachand	100.00			Ma Retraite LLC	Genoa	Real Estate Holding
				Avancer LLC	Genoa	CILA Operations
				Ma Maison LLC	Genoa	CILA Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Repairs and maintenance	\$	Ma Retraite LLC	100.00%	\$ (13,944)	\$ (13,944)	1
2	V	19 Professional Fees		Ma Retraite LLC	100.00%	11,585	11,585	2
3	V	20 Dues, fees, subscriptions		Ma Retraite LLC	100.00%	200	200	3
4	V	21 Office supplies		Ma Retraite LLC	100.00%	62	62	4
5	V	26 Insurance		Ma Retraite LLC	100.00%	260	260	5
6	V	30 Depreciation		Ma Retraite LLC	100.00%	12,600	12,600	6
7	V	32 Interest		Ma Retraite LLC	100.00%	29,672	29,672	7
8	V	33 Real estate taxes		Ma Retraite LLC	100.00%	19,710	19,710	8
9	V	34 Rent - facility & grounds		Ma Retraite LLC	100.00%	(211,710)	(211,710)	9
10	V	n/a Miscellaneous income		Ma Retraite LLC	100.00%	(7,976)	(7,976)	10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ (159,541)	\$ * (159,541)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/02 Ending: 6/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Catherine A. Bachand	Administrator	Administration	100.00	75,627	36	75.00	Salary	\$ 226,884	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7	Note: The 75,627 is received from the Day Training Program that is run by Genesis Enterprises. Amount is adjusted										7
8	out on line 43.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 226,884		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House# 0031906

Report Period Beginning:

07/01/02

Ending:

6/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4	N/A								4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House # 0031906 Report Period Beginning: 07/01/02 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Advance Leasing Corp		x	Heating and cooling system	\$803.00	9/99	\$ 33,301	\$ 10,205	9/04	0.1573	\$ 2,248	1	
2	ABB Business Finance		x	Telephone system	\$394.00	12/01	16,957	13,038	12/06	0.1396	2,029	2	
3	GreatAmerica Leasing		x	Time clock	\$338.00	3/02	9,217	5,753	3/05	0.1902	1,378	3	
4	Resource Bank		x	Mortgage	\$11,250.00	2/02	450,000	323,625	3/12	Prime	31,121	4	
5												5	
	Working Capital												
6	Resource Bank		x	Working capital	N/A	4/02	Various	275,937	4/03	0.1140	44,209	6	
7												7	
8												8	
9	TOTAL Facility Related				\$12,785.00		\$ 509,475	\$ 628,558			\$ 80,985	9	
	B. Non-Facility Related*												
10	Interest income offset										(23,553)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (23,553)	14	
15	TOTALS (line 9+line14)						\$ 509,475	\$ 628,558			\$ 57,432	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ -0- Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Genesis House**# **0031906** Report Period Beginning: **07/01/02** Ending: **6/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	18,965	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2002	\$	18,965	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	19,710	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	19,710	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	22,319	8		FOR OHF USE ONLY	
	1999	24,227	9			
	2000	17,406	10	13	FROM R. E. TAX STATEMENT FOR 2002	13
	2001	18,708	11	14	PLUS APPEAL COST FROM LINE 5	14
	2002	19,221	12	15	LESS REFUND FROM LINE 6	15
2nd installment of 2001-	9,610	Real Estate Taxes paid include:		16	AMOUNT TO USE FOR RATE CALCULATION	16
1/2 of 2002 taxes w/ 3% increase	10,100	2002 Taxes	9,354			
		2003 Taxes	9,611			
2003 Accrual	19,710	Total	18,965			

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Genesis House COUNTY DeKalb

FACILITY IDPH LICENSE NUMBER 0031906

CONTACT PERSON REGARDING THIS REPORT Catherine Bachand

TELEPHONE (815) 784-5146 FAX #: (815) 734 - 7131

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>03-29-152-010</u>	<u>350 Sycamore Road, Genoa, IL</u>	\$ <u>19,221.00</u>	\$ <u>19,221.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>19,221.00</u>	\$ <u>19,221.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,500
 B. General Construction Type:
 Exterior Brick
 Frame Wood
 Number of Stories 1

C. Does the Operating Entity?
 (a) Own the Facility
 (x) (b) Rent from a Related Organization.
 (x) (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (x) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

 E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 (X) NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	92,000	2002	\$ 122,310	1
2					2
3	TOTALS	92,000		\$ 122,310	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		2002	1972	\$ 440,888	\$ 12,600	35	\$ 12,600		\$ 14,699	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold improvements			1988	572		15	21		572	9
10	Roof			1992	34,891		15	2,326		26,749	10
11	Plumbing			1991	1,594		5			1,594	11
12	Office furniture partitions			1992	4,192	212	15	280	69	2,940	12
13	Office furniture partitions			1993	1,302	68	15	87	19	914	13
14	Landscaping			1993	13,295	669	15	886		9,303	14
15	Tile			1993	5,177		15	345	345	3,623	15
16	Drywall			1993	2,500		15	167		1,753	16
17	Building repair			1994	1,485		30	49	49	418	17
18	Alarm system			1994	5,391		30	180	180	1,530	18
19	Road paving			1994	36,015		30	1,201	1,201	10,208	19
20	Window and door replacement			1994	27,934		30	931	931	7,914	20
21	Parking lot repair			1994	796		30	27	27	229	21
22	Heating and air conditioning			1994	15,850		30	528	528	4,487	22
23	Parking lot sidewalk repair			1995	64,241		30	2,141	2,141	16,058	23
24	Plumbing, heating, electrical, carpeting			1996	12,760		30	425	425	2,763	24
25	Building repair - new windows			1997	9,930	993	25	397	(596)	2,184	25
26	Building repair to kitchen			1998	4,137	413	25	165	(248)	908	26
27	Bathroom repairs			1998	11,990		25	480	480	2,160	27
28	Windows			1999	34,053	905	15	2,271	1,366	7,948	28
29	Shower door			1999	690	69	10	69		242	29
30	HVAC units			1999	77,202	5,610	15	5,147	(463)	18,014	30
31	Sealcoating			2002	2,108	210	15	140	(70)	210	31
32	Non-facility depreciation					5,000			(5,000)		32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 808,993	\$ 26,748		\$ 30,863	\$ 1,384	\$ 137,420	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 133,917	\$ 21,820	\$ 20,412	\$ (1,408)	5-10	\$ 76,895	71
72	Current Year Purchases	5,565	556	556		5	556	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 139,482	\$ 22,376	\$ 20,968	\$ (1,408)		\$ 77,451	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1985 Ford Van	1987	\$ 13,039	\$	\$			\$ 13,039	76
77	Administrative	1996 Ford Escort	1995	14,431					14,431	77
78										78
79										79
80	TOTALS			\$ 27,470	\$	\$			\$ 27,470	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,098,255	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,124	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,831	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,707	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 242,341	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 6,523 Description: Copier - \$4847, Postage meter - \$1676

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident care</u>	<u>Vans</u>	\$ <u>1765</u>	\$ <u>21,150</u>	17
18	<u>Administrative</u>	<u>2001 Lexus</u>	<u>1455</u>	<u>17,463</u>	18
19					19
20					20
21	TOTAL		\$	\$ 38,613	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>42</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		347		347
3	Classroom Wages (a)		15,666		15,666
4	Clinical Wages (b)		7,888		7,888
5	In-House Trainer Wages (c)		6,858		6,858
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	30,759	\$	30,759
10	SUM OF line 9, col. 1 and 2 (e)	\$	30,759		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ 31,148

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	23

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L39, C3	visits		30	1,800		30	1,800	5
6	Dental Care	L39, C3	visits		23	1,400		23	1,400	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	53	\$ 3,200	\$	53	\$ 3,200	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 280,233	\$ 323,012	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	579,517	579,517	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,670	5,670	6
7	Other Prepaid Expenses	165	165	7
8	Accounts Receivable (owners or related parties)	216,124	165,476	8
9	Other(specify): Due from Shareholder	250,238	250,238	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,331,947	\$ 1,324,078	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		122,310	13
14	Buildings, at Historical Cost		440,888	14
15	Leasehold Improvements, at Historical Cost	150,808	368,105	15
16	Equipment, at Historical Cost	145,711	166,952	16
17	Accumulated Depreciation (book methods)	(163,429)	(242,341)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Deposits	5,803	5,803	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 138,893	\$ 861,717	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,470,840	\$ 2,185,795	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,173	\$ 21,173	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	298,517	298,517	29
30	Accrued Salaries Payable	71,490	71,490	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,792	19,710	32
33	Accrued Interest Payable		2,151	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,972	\$ 413,041	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,416	6,416	39
40	Mortgage Payable		323,625	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,416	\$ 330,041	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 414,388	\$ 743,082	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,056,452	\$ 1,442,713	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,470,840	\$ 2,185,795	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,375,875	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,375,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	280,577	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (319,423)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,056,452	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,728,425	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,728,425	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	31,148	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,542	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,690	23
D. Non-Operating Revenue			
24	Contributions	155	24
25	Interest and Other Investment Income***	23,553	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,708	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule 19A	53,921	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 53,921	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,839,744	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	476,860	31
32	Health Care	975,985	32
33	General Administration	694,218	33
B. Capital Expense			
34	Ownership	344,683	34
C. Ancillary Expense			
35	Special Cost Centers	874,901	35
36	Provider Participation Fee	192,520	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,559,167	40
41	Income before Income Taxes (line 30 minus line 40)**	280,577	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 280,577	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Federal Income Tax Return is filed using cash basis on a calendar year.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Genesis Enterprises, Inc.
Provider #0031906
6/30/2003

Schedule 19A

XVII. Income Statement
Other Revenue

E. Other Revenue (specify):	Amount
Management Fee Income	48,000
Vending Machine Income	5,821
Miscellaneous Income	<u>100</u>
Total	<u><u>53,921</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Genesis House

0031906

Report Period Beginning: 07/01/02

Ending: 6/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,346	2,614	\$ 61,354	\$ 23.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24	24	518	21.58	3
4	Licensed Practical Nurses	2,755	3,013	55,313	18.36	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,806	2,806	30,412	10.84	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	783	816	10,859	13.31	9
10	Activity Assistants	3,839	4,082	34,789	8.52	10
11	Social Service Workers	505	534	6,014	11.26	11
12	Dietician	1,448	1,643	23,731	14.44	12
13	Food Service Supervisor					13
14	Head Cook	5,329	5,597	43,214	7.72	14
15	Cook Helpers/Assistants	5,194	5,206	33,403	6.42	15
16	Dishwashers					16
17	Maintenance Workers	3,886	4,150	38,742	9.34	17
18	Housekeepers	10,604	10,831	78,301	7.23	18
19	Laundry	1,515	1,651	12,113	7.34	19
20	Administrator	3,712	3,921	268,810	68.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,346	7,918	84,733	10.70	24
25	Vocational Instruction					25
26	Academic Instruction	1,123	1,246	16,927	13.59	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,557	3,747	50,863	13.57	28
29	Resident Services Coordinator	1,664	1,840	31,038	16.87	29
30	Habilitation Aides (DD Homes)	41,850	42,676	475,373	11.14	30
31	Medical Records	1,199	1,320	13,703	10.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,485	105,635	\$ 1,370,210 *	\$ 12.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	154	\$ 7,230	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	85	2,958	L10, C3	38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant	160	7,223	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	25	1,415	L10A, C3	43
44	Activity Consultant	45	2,726	L11, C3	44
45	Social Service Consultant	17	1,036	L12, C3	45
46	Other(specify)				46
47	Psychiatric Consultant	14	2,939	L10, C3	47
48	Psychologist Consultant	68	5,100	L10, C3	48
49	TOTAL (lines 35 - 48)	568	\$ 56,427		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	3,023	115,566	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,023	\$ 115,566		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Genesis House**# **0031906**Report Period Beginning: **07/01/02**Ending: **6/30/03****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
Catherine A. Bachand	Administrator	100	\$ 226,884	Workers' Compensation Insurance	\$	26,438	IDPH License Fee	\$
Desiree Henderson-Sawyer	Administrator	0	41,926	Unemployment Compensation Insurance		13,354	Advertising: Employee Recruitment	4,175
				FICA Taxes		96,615	Health Care Worker Background Check (Indicate # of checks performed <u>219</u>)	1,532
				Employee Health Insurance		17,503	Licenses and permits	210
				Employee Meals		11,742	Dues and subscriptions	1,194
				Illinois Municipal Retirement Fund (IMRF)*				
				Other Employee Benefits		1,157		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 268,810					
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	166,809	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,111
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
American Express Tax & Business	Accounting	\$ 19,542					Out-of-State Travel	\$
Altschuler Melvoin & Glasser	Accounting	23,753						
Piper Rudnick	Legal	30,661					In-State Travel	
Shelsky & Froelick Ltd	Legal	566		N/A				
Genoa Computers	Computer services	1,404						
Health Data Systems	Computer services	1,274						
Information Controls	Computer services	1,523						
Thelen Computer Consulting	Computer services	3,980					Seminar Expense	4,585
Peachtree	Computer services	278						
ADP	Payroll services	8,679						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 91,660	TOTAL			\$	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	\$ 4,585

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Genesis House
Provider #: 0031906
07/01/02 to 6/30/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	91,660
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Plus: Shefsky & Froelick Ltd - legal from related organization	11,585
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Total (agree to Schedule V, line 19, column 8)	<u>103,245</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

(continued from page 1)													
1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Repairs to refrigeration	9/99	\$ 2,936	3	\$ 489	\$ 979	\$ 979	\$ 489	\$	\$	\$	\$	\$
2	Electrical work	10/99	2,999	3	500	1,000	1,000	499					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,935		\$ 989	\$ 1,979	\$ 1,979	\$ 988	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Genesis House

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5.0
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,525 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 192,520
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 11,742 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Genesis House

11:53 AM 11/4/2005

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,043,274	equal to	-1,043,274	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	57,432	equal to	57,432	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,710	equal to	19,710	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	51,831	equal to	51,831	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	45,136	equal to	45,136	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	30,759	equal to	30,759	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	8,638	equal to	8,638	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	476,860	equal to	476,860	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	975,985	equal to	975,985	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	694,218	equal to	694,218	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	344,683	equal to	344,683	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	874,901	equal to	874,901	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	192,520	equal to	192,520	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	705,089	equal to	705,089	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	30,412	< or = to	30,412	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	45,648	equal to	45,648	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	6,014	equal to	6,014	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	100,348	equal to	100,348	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	38,742	equal to	38,742	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	78,301	equal to	78,301	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	12,113	equal to	12,113	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	268,810	equal to	268,810	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	84,733	equal to	84,733	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,370,210	equal to	1,370,210	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	7,230	< or = to	7,230	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	120,324	< or = to	129,887	-9,563	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,726	< or = to	2,726	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,036	< or = to	1,036	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	268,810	equal to	268,810	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	91,660	equal to	91,660	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	166,809	equal to	166,809	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,111	equal to	7,111	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,585	equal to	4,585	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	192,520	equal to	192,520	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,742	< or = to	11,742	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,742	equal to	11,742	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	30,412	equal to	30,412	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-159,541	equal to	-159,541	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	628,558	equal to	628,558	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	19,710	equal to	19,710	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	122,310	equal to	122,310	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	808,993	equal to	808,993	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	166,952	equal to	166,952	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	242,341	equal to	242,341	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,056,452	equal to	1,056,452	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	280,577	equal to	280,577	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,470,840	equal to	1,470,840	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter One Center Expenses	What would CHANGES THE SUPPORT COST? That's (L) over (R) to the COST SUPPORT			11 \$5,650.00
Help number	Name	Amount	Amount	
Cost report period	From	01/01/2012	01/01/2012	Base Number 33
Enter a new 01/01/2012 facility, enter a 1 in cell C		21,800 (months)	21,800 (Pct of occupancy)	98.12%
Current last day		0		
Enter Total Cost Support/Line				
Card Services Salary/Wage	228,500 (Card L, Line 8 - (check))			
Card Admin Salary/Wage	303,500 (Card L, Line 28 - (check))			
Total Salary/Wage	1,076,210 (Card L, Line 46 - (check))			
Employee Benefits	908,000 (Card L, Line 52 - (check))			
Total Services Admin	492,160 (Card L, Line 8 - (check))			
Total General Admin	717,817 (Card 28 - (check))			

A	<p>Adaptive Support Services for Academic Success</p> <p>These support services are designed to help students succeed in their academic programs. They include:</p> <ul style="list-style-type: none"> Academic Advising: One-on-one meetings with advisors to help students choose courses and develop academic plans. Writing Center: Assistance with writing assignments, including essays, research papers, and lab reports. Math Tutoring: Individualized help with math concepts and problem-solving. Language Learning: Resources for students learning a second language, including conversation practice and grammar lessons. Study Skills: Workshops and materials to improve time management, note-taking, and test-taking strategies. 	
	<p>General Services</p> <p>These services are available to all students and are designed to support their overall well-being and success. They include:</p> <ul style="list-style-type: none"> Financial Aid: Assistance with applying for federal, state, and institutional aid. Health Services: On-campus health center providing medical care, counseling, and referrals. Career Center: Help with resume writing, job searching, and internship opportunities. Student Union: A central location for student activities, events, and services. 	
	<p>Specialized Support Services</p> <p>These services are designed to meet the specific needs of students with disabilities or other special circumstances. They include:</p> <ul style="list-style-type: none"> Disability Services: Coordination of accommodations for students with physical, learning, or mental health disabilities. Domestic Violence Support: Counseling, legal advocacy, and safety planning for students affected by domestic violence. Substance Use Support: Assessment, counseling, and referral to treatment for students with substance use issues. 	
B	<p>Student Development</p> <p>These programs and activities are designed to help students grow personally, socially, and academically. They include:</p> <ul style="list-style-type: none"> Orientation Programs: New student orientation and transfer student orientation. Leadership Programs: Opportunities to develop leadership skills through various organizations and roles. Work-Study Programs: Part-time employment opportunities on campus. Student Organizations: A wide variety of clubs and groups representing different interests and cultures. 	
	<p>Research and Academic Support</p> <p>These services are designed to support students in their academic research and learning. They include:</p> <ul style="list-style-type: none"> Research Centers: Specialized centers for research in various fields, such as biology, chemistry, and social sciences. Academic Support Centers: Centers providing resources and support for students in specific academic disciplines. Library Services: Access to a vast collection of books, journals, and digital resources. Writing Center: Assistance with research papers and academic writing. 	
	<p>Community and Outreach</p> <p>These programs are designed to engage students in service to the community and promote social responsibility. They include:</p> <ul style="list-style-type: none"> Service Learning: Integrating community service with academic coursework. Outreach Programs: Initiatives to provide support and resources to underserved populations. Environmental Stewardship: Programs focused on sustainability and environmental conservation. 	
C	<p>Student Health and Wellness</p> <p>These services are designed to promote the physical, mental, and emotional well-being of students. They include:</p> <ul style="list-style-type: none"> Health Services: On-campus health center providing medical care, counseling, and referrals. Mental Health Services: Counseling and support for students with mental health concerns. Physical Education: Required and elective courses to promote physical fitness. Nutrition Services: Workshops and resources to promote healthy eating habits. 	
	<p>Student Financial Services</p> <p>These services are designed to help students manage their financial needs and responsibilities. They include:</p> <ul style="list-style-type: none"> Financial Aid Office: Assistance with applying for and managing financial aid. Student Union: A central location for student activities, events, and services. Work-Study Programs: Part-time employment opportunities on campus. Student Organizations: A wide variety of clubs and groups representing different interests and cultures. 	
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Year	Information Modules		
	Base	General	General + Information
1983	1.1742	1.1742	1.1742
1984	1.1718	1.1718	1.1718
1985	1.1716	1.1716	1.1716
1986	1.1697	1.1697	1.1697
1987	1.1685	1.1685	1.1685
1988	1.1688	1.1688	1.1688
1989	1.1688	1.1688	1.1688
1990	1.1688	1.1688	1.1688
1991	1.1688	1.1688	1.1688
1992	1.1688	1.1688	1.1688
1993	1.1688	1.1688	1.1688
1994	1.1688	1.1688	1.1688
1995	1.1688	1.1688	1.1688
1996	1.1688	1.1688	1.1688
1997	1.1688	1.1688	1.1688
1998	1.1688	1.1688	1.1688
1999	1.1688	1.1688	1.1688
2000	1.1688	1.1688	1.1688
2001	1.1688	1.1688	1.1688
2002	1.1688	1.1688	1.1688
2003	1.1688	1.1688	1.1688
2004	1.1688	1.1688	1.1688
2005	1.1688	1.1688	1.1688
2006	1.1688	1.1688	1.1688
2007	1.1688	1.1688	1.1688
2008	1.1688	1.1688	1.1688
2009	1.1688	1.1688	1.1688
2010	1.1688	1.1688	1.1688
2011	1.1688	1.1688	1.1688
2012	1.1688	1.1688	1.1688
2013	1.1688	1.1688	1.1688
2014	1.1688	1.1688	1.1688
2015	1.1688	1.1688	1.1688
2016	1.1688	1.1688	1.1688
2017	1.1688	1.1688	1.1688
2018	1.1688	1.1688	1.1688
2019	1.1688	1.1688	1.1688
2020	1.1688	1.1688	1.1688
2021	1.1688	1.1688	1.1688
2022	1.1688	1.1688	1.1688
2023	1.1688	1.1688	1.1688
2024	1.1688	1.1688	1.1688
2025	1.1688	1.1688	1.1688
2026	1.1688	1.1688	1.1688
2027	1.1688	1.1688	1.1688
2028	1.1688	1.1688	1.1688
2029	1.1688	1.1688	1.1688
2030	1.1688	1.1688	1.1688
2031	1.1688	1.1688	1.1688
2032	1.1688	1.1688	1.1688
2033	1.1688	1.1688	1.1688
2034	1.1688	1.1688	1.1688
2035	1.1688	1.1688	1.1688
2036	1.1688	1.1688	1.1688
2037	1.1688	1.1688	1.1688
2038	1.1688	1.1688	1.1688
2039	1.1688	1.1688	1.1688
2040	1.1688	1.1688	1.1688
2041	1.1688	1.1688	1.1688
2042	1.1688	1.1688	1.1688
2043	1.1688	1.1688	1.1688
2044	1.1688	1.1688	1.1688
2045	1.1688	1.1688	1.1688
2046	1.1688	1.1688	1.1688
2047	1.1688	1.1688	1.1688
2048	1.1688	1.1688	1.1688
2049	1.1688	1.1688	1.1688
2050	1.1688	1.1688	1.1688
2051	1.1688	1.1688	1.1688
2052	1.1688	1.1688	1.1688
2053	1.1688	1.1688	1.1688
2054	1.1688	1.1688	1.1688
2055	1.1688	1.1688	1.1688
2056	1.1688	1.1688	1.1688
2057	1.1688	1.1688	1.1688
2058	1.1688	1.1688	1.1688

Total:

30th	Between 30th and 70th	70th	30th
Percentage	Percentage	Percentage	Percentage
31.77	2.40	1	44.44
31.77	2.40	10.50	24.67
26.73	2.30	3	32.76
27.63	2.60	0	35.30
27.63	2.60	0	36.40
31.76	0.070	6	40.66
31.76	0.070	7	40.66
31.76	0.070	8	40.66
30.77	0.176	9	37.83
30.77	0.176	10	36.86
26.69	0.893	11	10.70

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	100,348	3,519	7,230	111,097	0	111,097	0	111,097
2. Food Purchase	0	101,135	0	101,135	0	101,135	-11,742	89,393
3. Housekeeping	78,301	19,864	0	98,165	0	98,165	0	98,165
4. Laundry	12,113	10,164	390	22,667	0	22,667	0	22,667
5. Heat and Other Utilities	0	0	49,774	49,774	0	49,774	0	49,774
6. Maintenance	38,742	14,217	41,063	94,022	0	94,022	-12,956	81,066
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	229,504	148,899	98,457	476,860	0	476,860	-24,698	452,162
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	705,089	19,394	129,887	854,370	0	854,370	0	854,370
10a. Therapy	0	0	8,638	8,638	0	8,638	0	8,638
11. Activities	45,648	2,794	2,726	51,168	0	51,168	0	51,168
12. Social Services	6,014	0	1,036	7,050	0	7,050	0	7,050
13. Nurse Aide Training	30,412	347	0	30,759	0	30,759	0	30,759
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	787,163	22,535	166,287	975,985	0	975,985	0	975,985
17. Administrative	268,810	0	0	268,810	0	268,810	0	268,810
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	91,660	91,660	0	91,660	11,585	103,245
20. Fees, Subscriptions & Promotion	0	0	5,529	5,529	0	5,529	1,582	7,111
21. Clerical & General Office	84,733	6,498	20,224	111,455	0	111,455	-1,470	109,985
22. Employee Benefits & Payroll	0	0	155,067	155,067	0	155,067	11,742	166,809
23. Inservice Training & Education	0	0	1,766	1,766	0	1,766	0	1,766
24. Travel and Seminar	0	0	4,585	4,585	0	4,585	0	4,585
25. Other Admin. Staff Trans	0	0	12,817	12,817	0	12,817	0	12,817
26. Insurance-Prop.Liab.Malpractice	0	0	42,529	42,529	0	42,529	260	42,789
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	353,543	6,498	334,177	694,218	0	694,218	23,699	717,917
29. Total General Administrative	1,370,210	177,932	598,921	2,147,063	0	2,147,063	-999	2,146,064
30. Depreciation	0	0	36,524	36,524	0	36,524	15,307	51,831
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	51,313	51,313	0	51,313	6,119	57,432
33. Real Estate	0	0	0	0	0	0	19,710	19,710
34. Rent - Facility & Grounds	0	0	211,710	211,710	0	211,710	-211,710	0
35. Rent - Equipment & Vehicles	0	0	45,136	45,136	0	45,136	0	45,136
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	344,683	344,683	0	344,683	-170,574	174,109
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	3,200	3,200	0	3,200	0	3,200
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	192,520	192,520	0	192,520	0	192,520
43. Other (specify):*	0	0	871,701	871,701	0	871,701	-871,701	0
44. Total Special Cost Ce	0	0	1,067,421	1,067,421	0	1,067,421	-871,701	195,720
45. Grand Total	1,370,210	177,932	2,011,025	3,559,167	0	3,559,167	-1,043,274	2,515,893

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	280,233	323,012
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	579,517	579,517
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	5,670	5,670
7. Other Prepaid Expenses	165	165
8. Accounts Receivable-Owner/Related Party	216,124	165,476
9. Other (specify):	250,238	250,238
10. Total current assets	1,331,947	1,324,078
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	122,310
14. Buildings, at Historical Cost	0	440,888
15. Leasehold Improvements, Historical Cost	150,808	368,105
16. Equipment, at Historical Cost	145,711	166,952
17. Accumulated Depreciation (book methods)	-163,429	-242,341
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	5,803	5,803
23. other (specify):	0	0
24. Total Long-Term Assets	138,893	861,717
25. Total Assets	1,470,840	2,185,795
CURRENT LIABILITIES		
26. Accounts Payable	21,173	21,173
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	298,517	298,517
30. Accrued Salaries Payable	71,490	71,490
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	16,792	19,710
33. Accrued Interest Payable	0	2,151
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	407,971	413,040
LONG TERM LIABILITES		
39. Long-Term Notes Payable	6,416	6,416
40. Mortgage Payable	0	323,625
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	6,416	330,041
46. Total Liabilities	414,387	743,081
47. Total Equity	1,056,453	1,442,714
48. Total Liabilities and Equity	1,470,840	2,185,795

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,728,425
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	3,728,425
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	31,148
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	2,542
22. Laundry	0
Subtotal - Other Operating Revenue	33,690
24. Contributions	155
25. Interest and Other Investments Income	23,553
Subtotal - Non-Operating Revenue	23,708
27. Other Revenue (specify):	53,921
28. Other Revenue (specify):	0
Subtotal - Other Revenue	53,921
30. Total Revenue	3,839,744
31. General Services	476,860
32. Health Care	975,985
33. General Administration	694,218
34. Ownership	344,683
35. Special Cost Centers	874,901
35. Provider Participation Fee	192,520
37. Other	0
40. Total Expenses	3,559,167
41. Income Before Income Taxes	280,577
42. Income Taxes	0
43. Net Income or Loss for the Year	280,577

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23 Provider Participation fee is linked from page 4